EST. 1965

LEE OBSTETRICS
& GYNECOLOGY

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

Patient Name: _____ **Patient DOB**: _____

I request and authorize my previous mammography medical records to be released for comparison from:

☐ Breast Health Center
Auburn Medical Pavillion
900 Camp Auburn Road
Suite 300
Auburn, AL 36832
Phone: (334) 364 - 3165
Fax: (334) 364 - 3166

☐ Bridgeway Diagnostic
1910 East Samford Avenue
Auburn, AL 36830
Phone: (334) 539 - 5700
Fax: (334) 539 - 5704

☐ Other
Name/Facility: _____
Address: _____
_____
Phone: _____ Fax: _____

This authorization permits the Prior Health Care Provider to use and/or disclose the following individually identifiable health information about me to Lee Obstetrics & Gynecology.

When my information is used or disclosed pursuant to this authorization, it may be Protected Health Information and subject to The HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Prior Health Care Provider. This authorization shall be in effect until two years from date of execution at which time this authorization expires.

Signed by: _____ Date: _____

DIRECTIONS FOR IMAGING CENTERS:

Please send **MOST RECENT 8 YEARS OF BREAST IMAGING EXAMS, INCLUDING ANY SCREENING AND DIAGNOSTIC MAMMOGRAMS/ULTRASOUND/PATHOLOGY IMAGES AND REPORTS** by VPN, cloud image transmission, or CD/DVD in DICOM format.

Records should be mailed and/or faxed to:
Lee Obstetrics & Gynecology
2375 Champions Blvd, Suite #2
Auburn, AL 36830
Phone (334)745-6447
Fax (334) 659-4912